

This policy brief deals with research on the issue of affordability of health insurance in South Africa. The levels of income in the country and the impact of direct and income cross-subsidies on the affordability of health insurance are explored. A methodology is presented for exploring the effects of reform on families and the effect on affordability of the proposed health insurance reforms.

The General Household Survey (GHS) 2008 from StatsSA shows that only about 26% of South Africa's population are working and earning, leaving 74% who are not earning. 25% are children under age 20 and a further 25% receive some form of social grant. Moreover, only 9% earn above the tax threshold. This is significant since medical scheme coverage has a strong pattern by income – coverage is at around 80% for the highest income groups.

Söderlund & Peprah used 10% of income as a threshold above which premiums for the minimum package of benefits are unaffordable. The Ministerial Task Team (MTT) on Social Health Insurance, in 2005, found that contributions over 16% of per capita income are a severe barrier to medical scheme access and that affordability of cover is highly sensitive to family size in "low income" families.

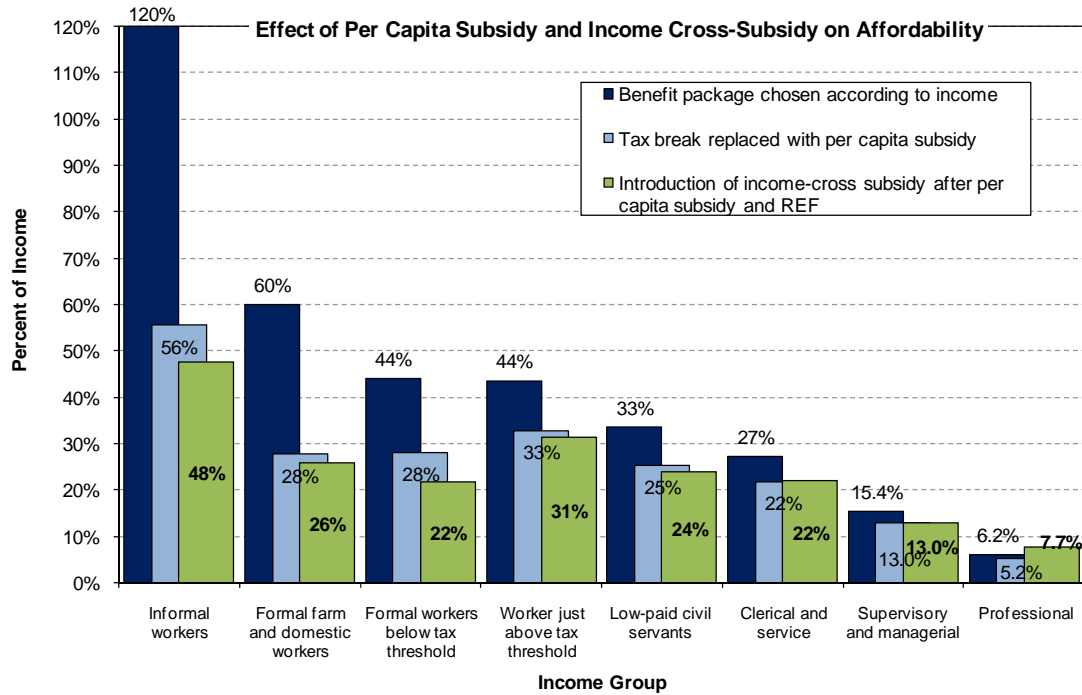
The studies also considered using subsidies and cross-subsidies to improve affordability. Söderlund & Peprah felt a direct subsidy or a mandated cross-subsidy across income groups was needed. The MTT found compulsory contributions at various income thresholds improved coverage but if only earners contribute, covering the full population is unaffordable at the current level of economic development.

The Low Income Medical Schemes (LIMS) process which reported in 2006 focused on people earning between R2,000 and R6,500 per month. This is the most comprehensive study to date of the affordability problem for low-income workers. The LIMS report found that out-of-pocket expenditure by households was between 3% and 10% of household income, while low-income members of medical schemes spent 7-9% of household income on medical scheme contributions. It was argued that premiums will therefore have to be substantially reduced from current levels if they are to lead to a material expansion in medical scheme coverage.

The LIMS report considered three broad sets of interventions that could reduce medical scheme premiums to low-income households: direct subsidies (from employers and/or the State); reductions to the benefits package; or reductions in the costs of healthcare goods and services. The report proposed a new, direct subsidy from the National Treasury to members of proposed LIMS schemes or options. If targeted appropriately, such subsidies would significantly impact on extending coverage.

McLeod & Grobler developed a methodology for demonstrating the effect of sequential reforms, and particularly the impact of reforms on low-income workers. Figure 1 shows the unaffordability of medical scheme packages, even if less comprehensive packages are chosen by lower-income workers. Families just below the tax threshold would still be faced with spending 44% of income on a medical scheme. The replacement of the current tax break for medical scheme membership with a per capita subsidy improves their position from 44% of income to 28%. The introduction of the Risk Equalisation Fund (REF) simultaneously with income cross-subsidies continues to lower contributions to 22% of income but this is still higher than the MTT benchmark of 16% of per capita income. In order to reduce contributions further for this family, it is necessary to have income cross-subsidies over a package greater than PMBs. The significant improvements in affordability for the lower-income groups can be accomplished with only minor increases for managerial and professional workers, which still amount to lower contributions than if there was no subsidy at all.

Over the years there have been several voices that have echoed the need for income-related cross-subsidies delivered via a risk equalisation mechanism, including the ANC Health Plan of 1994; the 1995 Committee of Inquiry into NHI; the 2002 Taylor Report on social security; the 2005 Ministerial Task Team on Social Health Insurance; and McIntyre & Van den Heever in 2007. A common, equal, subsidy for healthcare for every citizen, whether they use public or private facilities, could be paid to the provinces and distributed amongst medical schemes in a risk-adjusted way in order to ensure that the subsidy is allocated according to health need. This first step towards income cross-subsidies will have a major impact on improving the affordability of health insurance.



**Figure 1: Impact on Affordability: Per Capita Subsidy, REF and Income Cross-Subsidy**

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#### Further resources on the IMSA NHI web-site

[http://www.innovativemedicines.co.za/national\\_health\\_insurance.html](http://www.innovativemedicines.co.za/national_health_insurance.html)

- The full policy brief, as well as the slides and tables used, including additional slides showing each step in the sequence of reform model are provided.
- A spreadsheet of the results of the affordability and sequence of reform model by McLeod & Grobler, showing the effect on affordability of each step in the reform process.

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